

 The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. **NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately.** This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-312-906-8080 or go to [www.alliedbenefit.com](http://www.alliedbenefit.com). For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms, see the Glossary. You can view the Glossary at [www.alliedbenefit.com](http://www.alliedbenefit.com) or call 1-312-906-8080 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <a href="#">deductible</a>?</b>	\$7,000 person/ \$14,000 family In-Network; No non-emergency Out-of-Network coverage available (unless specifically stated in the Schedule of Covered Services).	Generally, you must pay all of the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes. In-network <a href="#">preventive care</a> is covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	\$7,000 person/ \$14,000 family In-Network; No non-emergency Out-of-Network coverage available (unless specifically stated in the Schedule of Covered Services).	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	Penalties for failure to obtain precertification, services in excess of Plan maximums or limits, <a href="#">premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	Yes. See <a href="http://www.alliedbenefit.com">www.alliedbenefit.com</a> or call 1-312-906-8080 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .



All [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	0% <a href="#">coinsurance</a>	No coverage	None.
	<a href="#">Specialist</a> visit	0% <a href="#">coinsurance</a>	No coverage	None.
	<a href="#">Preventive care/screening/immunization</a>	No charge ( <a href="#">deductible</a> does not apply).	No coverage	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services you need are preventive. Then check what your <a href="#">plan</a> will pay for.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	0% <a href="#">coinsurance</a>	No coverage	None.
	Imaging (CT/PET scans, MRIs)	0% <a href="#">coinsurance</a>	No coverage	None.
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.express-scripts.com">www.express-scripts.com</a> .	Generic drugs	Prescription Drugs purchased at a participating pharmacy (or through the Mail Order/Smart 90 Program) will be dispensed at a discounted rate provided You show Your member ID card at the time of purchase. Charges incurred for prescription drugs apply toward Your Deductible. After Your Deductible is met, the Plan will pay 100% of Your prescription costs		Covers up to a 30-day supply (retail prescription); 90-day supply (mail order and Smart 90 prescription). *See Plan Document for non-use of generic drug penalty.
	Preferred brand drugs			
	Non-preferred brand drugs			
	<a href="#">Specialty drugs</a>	Contact your prescription drug vendor, for applicable cost		*Please see Prescription Drug Benefit section within your Plan Document for details.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	0% <a href="#">coinsurance</a>	No coverage	None.
	Physician/surgeon fees	0% <a href="#">coinsurance</a>	No coverage	None.
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	0% <a href="#">coinsurance</a>		None.
	<a href="#">Emergency medical transportation</a>	0% <a href="#">coinsurance</a>	No coverage	Non-emergent and air ambulance services must be pre-certified in order to avoid \$200 penalty per occurrence.
	<a href="#">Urgent care</a>	0% <a href="#">coinsurance</a>	No coverage	Exam charge only.

\*For more information about limitations and exceptions, see plan document at [www.alliedbenefit.com](http://www.alliedbenefit.com).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	0% <a href="#">coinsurance</a>	No coverage	Services must be pre-certified in order to avoid \$200 penalty per occurrence.
	Physician/surgeon fees	0% <a href="#">coinsurance</a>	No coverage	None.
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	0% <a href="#">coinsurance</a>	No coverage	None.
	Inpatient services	0% <a href="#">coinsurance</a>	No coverage	Services must be pre-certified in order to avoid \$200 penalty per occurrence.
<b>If you are pregnant</b>	Office visits	0% <a href="#">coinsurance</a>	No coverage	<a href="#">Cost sharing</a> does not apply to certain <a href="#">preventive services</a> . Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Services must be pre-certified for vaginal deliveries requiring more than a 48 hour stay and for cesarean section deliveries requiring more than a 96 hour stay in order to avoid \$200 penalty.
	Childbirth/delivery professional services	0% <a href="#">coinsurance</a>	No coverage	
	Childbirth/delivery facility services	0% <a href="#">coinsurance</a>	No coverage	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	0% <a href="#">coinsurance</a>	No coverage	None.
	<a href="#">Rehabilitation services</a>	0% <a href="#">coinsurance</a>	No coverage	Physical, Occupational and Speech therapy are limited to a combined maximum of 62 Visits for office and Outpatient facility services, per Covered Person per Calendar Year. Does not include labs or x-rays.
	<a href="#">Habilitation services</a>	0% <a href="#">coinsurance</a>	No coverage	
	<a href="#">Skilled nursing care</a>	0% <a href="#">coinsurance</a>	No coverage	
	<a href="#">Durable medical equipment</a>	0% <a href="#">coinsurance</a>	No coverage	Select services must be pre-certified in order to avoid \$200 penalty per occurrence.
	<a href="#">Hospice services</a>	0% <a href="#">coinsurance</a>	No coverage	Includes all necessary services for the patient if prescribed by a Physician, and the patient's life expectancy is 6 months or less.
<b>If your child needs dental or eye care</b>	Children's eye exam	0% <a href="#">coinsurance</a>	No coverage	Applies from birth through age 5.
	Children's glasses	Not covered	Not covered	Not covered.
	Children's dental check-up	Not covered	Not covered	Not covered.

\*For more information about limitations and exceptions, see plan document at [www.alliedbenefit.com](http://www.alliedbenefit.com).

## Excluded Services & Other Covered Services:

### Services Your [Plan](#) Generally Does NOT Cover (Check your [plan](#) document for more information and a list of any other [excluded services](#).)

- Chiropractic care (other than exams)
- Cosmetic surgery
- Dental care (Adult)
- Dental check-up (Child)
- Glasses (Child)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Routine foot care

### Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- Acupuncture
- Bariatric surgery
- Home Health Care
- Infertility treatment (except promotion of conception)
- Private duty nursing
- Weight loss programs

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov). Other coverage options may be available to you too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the [Marketplace](#), visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: the Plan Administrator at (419) 267-2806 or the Ohio Superintendent of Insurance at 800-686-1526 or <https://secured.insurance.ohio.gov/ConsumServ/ConServComments.asp>.

**Does this plan provide Minimum Essential Coverage? Yes.**

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

**Does this plan meet Minimum Value Standards? Yes.**

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

————— *To see examples of how this plan might cover costs for a sample medical situation, see the next section.* —————

\*For more information about limitations and exceptions, see plan document at [www.alliedbenefit.com](http://www.alliedbenefit.com).

## About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$7,000
■ <a href="#">Specialist coinsurance</a>	0%
■ Hospital (facility) <a href="#">coinsurance</a>	0%
■ Other <a href="#">coinsurance</a>	0%

This EXAMPLE event includes services like:

[Specialist](#) office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
[Diagnostic tests](#) (*ultrasounds and blood work*)  
[Specialist](#) visit (*anesthesia*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$7,000
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$7,060</b>

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$7,000
■ <a href="#">Specialist coinsurance</a>	0%
■ Hospital (facility) <a href="#">coinsurance</a>	0%
■ Other <a href="#">coinsurance</a>	0%

This EXAMPLE event includes services like:

[Primary care physician](#) office visits (*including disease education*)  
[Diagnostic tests](#) (*blood work*)  
[Prescription drugs](#)  
[Durable medical equipment](#) (*glucose meter*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$5,600
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$5,620</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$7,000
■ <a href="#">Specialist coinsurance</a>	0%
■ Hospital (facility) <a href="#">coinsurance</a>	0%
■ Other <a href="#">coinsurance</a>	0%

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)  
[Diagnostic test](#) (*x-ray*)  
[Durable medical equipment](#) (*crutches*)  
[Rehabilitation services](#) (*physical therapy*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$2,800
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,800</b>